Care Quality Commission

Inspection Evidence Table

Park Lodge Medical Centre (1-5057630909)

Inspection date: 28/11/2019

Date of data download: 29 December 2019

Overall rating: Requires Improvement

The practice was rated as requirements improvement for the safe, effective, responsive and well led domains. The practice was rated as good for the caring. This gave the practice an overall rating of requires improvement.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires improvement

The practice was rated as requires improvement for safe services because:

- Two safety medication alerts had not been actioned.
- The practice did not follow best practice guidelines with regards to vaccination storage.
- The practice did not offer immunisations or hold a record of immunisation status for non-clinical staff members.
- Fire drills had not been regularly carried out and fire marshals had not received appropriate training.
- All patients were not followed up after being referred into the two-week wait (TWW) cancer referral system.
- Comprehensive health and safety risk assessments had not been carried out.
- The serial numbers of blank prescription pads given to specific prescribers were not recorded.

Safety systems and processes

The practice had some clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and	Y

Safeguarding	Y/N/Partial
communicated to staff.	
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: • There was a record of the immunisation status for all clinical staff. However, the practice did not have any evidence of the immunisation status of their non-clinical staff. Public Health England advises within the following guidance *'Immunisation of healthcare and laboratory staff: the green book, chapter 12, March 2013'* advises that non-clinical staff in a healthcare setting should be up to date with their routine immunisations, includingtetanus, diphtheria, polio and MMR. Immediately after the inspection, the practice provided evidence confirming that they had requested the vaccination status of all employees and would offer vaccinations to those who required it.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person.	Y

Date of last inspection/test: 11/04/2019	
There was a record of equipment calibration. Date of last calibration: 11/04/2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: Six fire extinguishers were checked, and all had been serviced within the past 12 months.	Y
There was a log of fire drills. Date of last drill: 15/11/2018.	Partial
There was a record of fire alarm checks. Date of last check: 31/05/2019	Y
There was a record of fire training for staff. Date of last training: Five out of five recruitment files checked had evidence of up to date fire training.	Y
There were fire marshals.	Partial
A fire risk assessment had been completed. Date of completion: 24/05/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: • We saw that the practice did not carry out planned fire drills. The last recorded fire drills were in September 2018 and November 2018; however, both were initiated from false alarms as opposed to scheduled fire drills. Immediately after the inspection, the practice informed us that they had scheduled a fire drill for 03/12/2019. During the factual accuracy process the provider confirmed the fire drill took place on 03/12/2019. • The practice appointed fire marshals, however the fire marshals had not received formal fire marshal training. Since the inspection, the practice advised that all fire marshals had received fire marshal training on 02/12/2019.	

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: 16/11/2019	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16/11/2019	Partial
Explanation of any answers and additional evidence: • The practice had carried out a health and safety risk assessment, however the assessment was generic and did not include a room by room risk assessment. Immediately after the inspection, the practice sent us an example of their new health and safety risk assessment template, which showed that each room within the premises would be risk assessed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 23/08/2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment, with exception of two-week wait referrals.

	Y/N/Partial

Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

- A 'two week wait' (TWW) referral is a request from a GP to ask the hospital for an urgent appointment for a patient, because they have symptoms that might indicate they have cancer. The practice's policy on TWW referrals was that the GP would make a referral by contacting the relevant hospital department and book the patient an appointment. GPs would ask all patients to contact the surgery if they had not been given an appointment within the two-week period. GP's would send an electronic task to themselves to follow up patients who had dementia, learning disabilities, mental health concerns or capacity issues. The policy did not ensure that patients who did not fall within the above categories were being followed up by their GPs to ensure they had been offered and then attended their TWW appointment.

Appropriate and safe use of medicines

The practice had some systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.12	0.75	0.87	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and	6.1%	10.7%	8.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	4.53	5.85	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	0.22	1.37	2.08	Significant Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A

Medicines management	Y/N/Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N
Explanation of any answers and additional evidence: • The practice had a policy of recording the serial numbers of new blank prescriptions that had been delivered and stored at the premise. However, they did have a record of the prescriptions which had been allocated to individual clinicians within the service. In accordance with the NHS Counter Fraud Authority document *"Management and control of prescription forms: A guidance for prescribers and health organisations" (March 2018),* it is advised that there should be a record of whom prescription forms have been allocated to, along with serial numbers for these forms. • In two of the four fridges examined, we found that influenza vaccines had been removed from their original packaging and placed into kidney bowls or baskets. This goes against best practice guidelines detailed in '*Green Book (June 2013, chapter 3 page 26 "Storage, distribution and disposal of vaccines' and Public Health England- Vaccine Incident Guidance: Responding to errors in vaccine storage, handling and administration, 2019'* which both state that vaccines must be stored in their original packaging prior to administrating them.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y

Number of events recorded in last 12 months:	11
Number of events that required action:	11

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
GP offered condolences to wrong patient	GP issued a sick note and offered condolences to wrong patient. This was identified by the patient who informed the GP that they had not suffered a bereavement. An apology was offered to the patient. This event was discussed with staff who were reminded the importance of double checking that correspondence is being sent to the correct patient.
Patient's weight was wrongly noted which led to an incorrect dosage of medicine being prescribed.	The GP offered an apology and prescribed the correct dosage of medicine. Doctors reminded to double check patients' weight before recording and calculating medication dosages.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

- Alerts were received electronically and disseminated by the practice management to all staff. All alerts were recorded on a register, which detailed the alert and the action taken. Staff gave examples of recent alerts they had actioned which had been recorded appropriately. For example, we saw a recent drug alert was recorded regarding faulty Emerade auto-injectors, the practice had carried out searches and informed all patients who carried the injector of the associated risks and where possible to carry an additional injector.
- However, despite the practice recording and actioning several safety alerts, it had missed two important safety alerts issued by Medicines & Healthcare products Regulatory Agency (MHRA). The practice had missed a MHRA alert issued in November 2018 regarding an antihypertensive medicine and the increased risk of developing non-melanoma skin cancer. We found that 31 patients were prescribed this medicine and had not been advised of the risks. In addition, the practice had missed another MHRA alert issued in February 2019 regarding an antithyroid medicine and the increased risk of developing pancreatitis and congenital malformations. We found that four patients were being administered this medication and had not been advised of the risks.
- After the inspection the practice advised us that all patients who were affected by the two missed safety alerts had been contacted and asked to come into the surgery to speak with a GP.

Effective Rating: Requires improvement

The practice was rated as requires improvement for effective services because:

- The practice's QOF performance was lower than local and national averages for the long-term conditions' indicators relating to diabetes and hypertension.
- Child immunisation uptake rates were below the World Health Organisation (WHO) targets.
- We were not satisfied that the practice had an effective system in place to ensure regular medicines and health reviews were undertaken for elderly patients and patients with gestational diabetes.
- We were not satisfied the practice had an effective system for sharing and cascading clinical learning amongst relevant staff.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: • During the inspection, we reviewed the records of seven patients who required regular medicine reviews and we found concerns with two of those records. One of the records indicated that the patient had not had a medication review since November 2013 and another record showed that a patient did not have a medication review since May 2016. Both these patients were over the age of 75. • We also reviewed two records of patients who had been diagnosed with gestational diabetes and found the practice had not reviewed their diabetes post-pregnancy. We were told that	

there was no formal re-call system to follow up patients who had being diagnosed with gestational diabetes to check whether the diabetes is still present or not.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.11	0.54	0.74	Significant Variation (positive)

Older people

Population group rating: Requires improvement

Findings

- The practice did not always carry out structured medication reviews for older people. We reviewed two records which did not have formal medication reviews since 2013 and 2016. The practice told us that it had recruited a new pharmacist who commenced work on 16/12/2019 and one of their roles was to carry out medication reviews.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group

People with long-term conditions

Population group rating: Requires improvement

Findings

- Patients with long-term conditions were offered a structed annual review to check their health and medicines needs were being met.
- The practice's QOF performance was lower than local and national averages for the long-term conditions' indicators relating to diabetes and hypertension (see below).
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a co-ordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding

care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	67.8%	74.1%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	()	-		N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	73.4%	81.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A
	Practice	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	73.0%	79.9%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	()	-		N/A
Other long-term conditions	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	75.3%	75.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in	91.3%	91.6%	89.6%	No statistical variation

the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	()	-		N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	74.5%	80.9%	83.0%	Variation (negative)
Exception rate (number of exceptions).	()	-		N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	86.5%	88.1%	91.1%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A

Any additional evidence or comments

The Quality and Outcomes Framework (QOF) allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores. Patients can be exception-reported from individual indicators for various reasons, for example if they do not attend appointments or where the treatment is judged to be inappropriate by the GP (such as medication cannot be prescribed due to side-effects). They can also be exception reported if they are no longer registered at the practice or they decline treatment or investigations.

The practice was aware that their QOF performance for diabetes and hypertension was below the national and local averages. The practice explained that it had not been exception reporting patients for the past two years as a list validation exercise was being undertaken during that time.

The practice told us the validation exercise was now complete and it would start exception reporting this year which they felt should increase their performance across all QOF indicators.

The practice also informed us that its clinical staff had recently completed advanced training for long-term conditions such as diabetes.

Families, children and young people

Population group rating: Requires improvement

Findings

- Child immunisation uptake rates were significantly below the World Health Organisation (WHO) targets (see below for more details)
- The practice had no yearly follow up for those with gestational diabetes and had no recall system in place for this. According to NICE guidance *"Diabetes in pregnancy: management from*

preconception to the postnatal period", patients who have experienced gestational diabetes should be offered a yearly HbA1c test to check that diabetes has not developed.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had set parameters with their online access to restrict access to all patients under 16 years old.
- Domestic violence training was delivered to all staff members in the practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%	Unverified and unpublished data
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	23	40	57.5%	Below 80% uptake	92.6%
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	50	86	58.1%	Below 80% uptake	81.5%
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	50	86	58.1%	Below 80% uptake	83.3%

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	50	86	58.1%	Below 80% uptake	81.5%

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Any additional evidence or comments

During our inspection, the practice provided us with unverified data from its records, based on its immunisation target payments, which showed a higher recorded childhood immunisation uptake across all four indicators (between 78%-91%). This is not the same data source as reported on and thus is not comparable.

After the inspection the practice provided us with evidence that their CCG had provided data which showed the uptake rate of childhood immunisations were higher than what was reported by the publishing body NHS England. Those figures are reported in the above box titled 'Unverified and unpublished data'. The unverified and unpublished data showed that the uptake rate was still below the World Health Organisation target of 95%.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice was aware it had not met the 80% national uptake target for cervical screening. The practice informed us it had experienced some cultural barriers with some population groups who expressed reluctance to engage with the cervical screening programme. We saw the practice ran regular reports to identify patients who were due for cervical screening tests. These patients would be called by the practice inviting them for a cervical screening test; if the patient did not respond they would be given a further telephone call and sent reminder letters.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women	70.4%	N/A	80% Target	Below 80% target

aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) **(PHE)**	70.1%	69.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) **(PHE)**	53.9%	49.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) **(PHE)**	91.7%	80.0%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	54.5%	52.7%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicine.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice hosted a mental health link worker who carried out consultations two days a week.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	88.0%	90.7%	89.4%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	82.0%	90.5%	90.2%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	73.5%	83.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A

Any additional evidence or comments
The practice was aware that their QOF performance for dementia was below the national and local averages. The practice again explained that it had not been exception reporting patients for the past two years as a list validation exercise was being undertaken during that time.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	512.3	534.7	539.2

Overall QOF score (as a percentage of maximum)	91.6%	95.7%	96.7%
Overall QOF exception reporting (all domains)	0%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:

The practice had undertaken three completed clinical audits in the last two years, including 2-cycle clinical audits, for example:

- The practice had undertaken an audit looking at dual anti platelet therapy (DAPT) following acute coronary syndrome (ACS) and checking whether this treatment was stopped in the appropriate timeframe.
- During the first cycle, the practice noted that treatment was only stopped within the correct timeframe for 28% of patients, the duration of the DAPT treatment period was stated on 50% of patient prescriptions, and 75% of hospital discharge summaries.
- As a result of this audit, the practice changed their procedure so that an end date was put on all prescriptions to prevent patients being on DAPT for longer than deemed necessary and liaised with secondary care providers to ensure it was also stated on discharge summaries.
- A second audit was undertaken and the practice had identified an improvement as treatment was stopped within the correct timeframe for 95% of patients, the duration of the DAPT treatment period was stated on 69% of patient prescriptions, and 82% of hospital discharge summaries.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, learning was not always effectively shared amongst staff.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample	Partial

taking for the cervical screening programme.	
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: • We found one member of the nursing team had attended a cervical screening face to face update in May 2019 and had documented learning for other necessary staff to view on the practice shared drive; however, this learning was not appropriately cascaded, and it was unclear whether other relevant members of staff had read this. We spoke to other nursing staff who were unaware of the contents of this training update. Since the inspection, the practice has provided assurances that all clinical staff had read through the training update and it changed its policy to ensure that all future training is shared, signed and logged by relevant staff members.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective	Y

processes to make referrals to other services.	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	95.1%	95.1%	95.0%	No statistical variation
Exception rate (number of exceptions).	()	-		N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Explanation of any answers and additional evidence:

- Policies and protocols were in place to ensure there was a standardised approach to obtaining consent.
- Clinical staff demonstrated good knowledge of the Mental Capacity Act.
- We saw evidence clinical staff were competent in identifying consent issues and understood the general principles of Gillick competencies and Fraser guidelines.

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	18
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comments cards	Patients commented that staff provide a helpful and friendly service and treated them with compassion, respect and kindness.
Patient Participation Group (PPG)	Members of the patient participation group told us they had always been treated with the highest level of kindness, respect and compassion.
Patient interviews	We interviewed 12 patients who all stated that that the practice staff was always caring towards them.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5687.0	336.0	113.0	33.6%	1.99%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	87.7%	84.7%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	83.9%	82.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	95.8%	92.8%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	68%	77.0%	82.9%	Tending towards variation (negative)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes
Any additional evidence	
The practice was aware of the low GP patient survey score relating to the overall patient experience at the GP practice. We were told that at the time of the of the national survey the data validation exercise was still on-going and the new telephone lines had not been installed. The practice told us that it had carried out its own internal survey in August 2019 in which 103 patients participated and 93% of patients responds positively to their overall experience at the practice.	

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	Patients told us they felt supported and were involved in decisions about care and treatment.
CQC Comment cards	Comments in general stated staff were always respectful and clinicians were caring and understanding.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	88.7%	90.1%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of	70 carers (1% of patient list).

carers identified.	The practice informed us it was always pro-actively trying to increase the number of carers identified within its patient list. They had a carers poster in the reception area and also provider information on being a carer on their website. The practice asked all new patients to disclose if they were a carer. The practice told us that 70 carers was identified for the Park Lodge Medical Centre practice list and another 260 had been identified for the Winchmore Hill practice list.
How the practice supported carers (including young carers).	The practice had a system that formally identified patients who were carers and written information was available for them signposting them to the various avenues of support. For example, a local carers organisation. Patients who were carers were offered annual health checks and influenza vaccinations. We were told that carers would also be given priority during their extended hours appointments.
How the practice supported recently bereaved patients.	The practice told us they would send a condolence card to bereaved patients and offered them an appointment with a GP.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Explanation of any answers and additional evidence:

The reception seating was away from the reception desk giving some privacy. We were told when a patient wished to discuss a matter in private, staff were aware they could take the patient to a private room for the discussion.

Patients we spoke with and CQC comment cards stated their privacy and dignity was always respected.

Responsive Rating: Requires Improvement

The practice was rated as requires improvement for Responsive services because:

- Since the last inspection in April 2018 there was continuing concerns and patient dissatisfaction regarding timely access to the practice via telephone; experience of making an appointment; and the appointment times offered. This affected all population groups who have been rated as requires improvement for the responsive domain.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am-8pm
Tuesday	8am-6.30pm
Wednesday	8am-8pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Appointments available:	
Monday	8.30am-8pm
Tuesday	8.30am-6pm

Wednesday	8.30am-8pm
Thursday	8.30am-6pm
Friday	8.30am-6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5687.0	336.0	113.0	33.6%	1.99%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	92.1%	91.3%	94.5%	No statistical variation

Older people

Population group rating: Requires improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice had a dedicated duty doctor available in the mornings who carried out home visits to avoid unnecessary hospital admissions.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires improvement

Findings

- Additional appointments were available until 8pm on a Monday and Wednesday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were, where possible, offered a same day appointment.
- The practice offered a comprehensive family planning and contraception service.
- The practice hosted midwives from a local hospital who ran ante-natal clinics at the practice.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- There was online patient access which allowed booking and cancelling appointments, prescription requests and viewing of medical summary. The surgery provided electronic prescribing allowing patients to nominate a pharmacy closer to their home or working place to collect their medication.
- The practice was open until 8pm on a Monday and Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area. The local Clinical Commissioning Group has commissioned an extended hours HUB service, which operates across two locations. The HUB sites operate from 6.30pm to 8.30pm on weekdays and 8am – 8pm on weekends.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning

disability.

- The practice offers longer consultation times, large number of on the day appointments and easily accessible telephone consultations to provide care for this group.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	30.0%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	42.8%	58.7%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	42.9%	59.7%	64.7%	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	61.9%	66.3%	73.6%	No statistical variation

Any additional evidence or comments
At the last inspection in April 2018, we identified concerns about patient dissatisfaction regarding telephone access and the experience of making an appointment. At that time the practice provided us with assurances that a new telephone system had been installed and additional staff had been hired to help improve the practice' service in these areas. However, the practice scored poorly in the latest published GP patient survey scores for questions relating to ease of access to the practice via telephone; experience of making an appointment; and the appointment times offered. The practice were aware of these low scores and again provided assurances that since the timeframe of the survey (January-March 2019) another telephone system had been installed, there was closer scrutiny of waiting times and more administrative staff were available to answer the telephones. The practice also told us that they carried out their own internal survey in August 2019 which was completed by 103 patients. That survey asked similar questions to the GP patient survey and in most of the questions they received a positive response from patients. The survey results indicated that 17% of patients were dissatisfied by the phone service and 25% said the phone service had not improved.

Source	Feedback
Patient interviews	We spoke with twelve patients on the day of the inspection, eight of the patients told us that they had recently had to wait over an hour on the telephone before a receptionist answered their call. These patients also told us that they had recently attended the surgery and had to wait in long queues before being seen.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	20
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	20
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

We were told GP Partners investigated complaints related to clinical matters and the practice manager dealt with non-clinical matters. Complaints we reviewed included concerns about waiting times on the phone and difficulties with making appointments. These were appropriately acknowledged, investigated and the findings were shared. Duty of candour was demonstrated in all the complaints we reviewed.

Well-led Rating: Requires improvement

The practice was rated as requires improvement for providing well-led services because:

We rated the practice as requires improvement for providing well-led services because the overall governance arrangements required improvement. The practice did not always have clear and effective processes for ensuring safe care and treatment and managing risks, issues and performance. The practice did not always act on appropriate and accurate information. There was also continuous concerns regarding access to the practice via telephone and the experience of making an appointment.

Leadership capacity and capability

There was some evidence of compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- The leadership team were aware of the challenges it faced. However, it could not always demonstrate that it had identified the correct actions to help improve those challenges. For example, the practice was unable to successfully carry out a data cleansing exercise for a period of two years and as a result this impacted the practice's clinical performance. Since the last inspection in April 2018, patients were still dissatisfied with telephone waiting times and the experience of making an appointment.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y

Staff had undertaken equality and diversity training.	Y

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews	We spoke with several members of staff during the inspection. All stated they felt well supported and that they had access to the equipment, tools and training necessary to enable them to perform their roles well. We were told staff were given protected time to enable them to undertake training and carry out non-clinical duties. Staff reported there were good, effective working relationships between managers and staff and clinical and non-clinical staff.

Governance arrangements

The overall governance arrangements requires improvement.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

- All staff interviewed during the day of inspection stated they understood their roles and responsibilities within the practice.
- All staff spoken with knew how and where to access relevant policies and procedures.
- While there were governance systems in place, these did not always identify issues and had not identified the areas of concern in the safe key question. For example, there were checks of the medicine fridges, but these had not identified the influenza vaccines were not being stored in line with requirements. There was a system for receiving and disseminating safety alerts but two important alerts were missed. There was no system to ensure all the patients referred under the two-week were followed up to ensure they had been offered and attended an appointment.
- There was a system for audit to demonstrate improved outcomes for patients however, the number of children who received immunisations was below the World Health Organisation targets and quality outcomes for diabetes and hypertension were lower than national and local averages.
- There was limited evidence of clinical learning being shared amongst relevant staff.
- The practice has continued to receive patient dissatisfaction with the telephone waiting time despite some efforts to improve the system.

Managing risks, issues and performance

The practice had some clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: • As identified above the practice did not have the appropriate arrangements in place to manage fire risk and health and safety at the premise.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: • As identified previously two MHRA alerts were not actioned. The practice did have a system in place to cascade these alerts; however, these two important alerts which affected a number of patients had not been actioned.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group (PPG).

Feedback
We received positive feedback from the PPG. The PPG has been merged since Park Lodge Medical Centre joined with Winchmore Hill Surgery and meetings would be held three times per year. Speakers were present at every meeting and minutes were calculated. The PPG felt that the practice listened to and acted upon their views, and would always share any learning regarding complaints, encouraging an open and honest culture.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement
• The practice had recruited a pharmacist, paramedic and social prescriber to help better meet the needs of the patient groups. • All staff have been provided with domestic violence training to increase awareness. • The practice works closely with the local frailty team to develop care plans for the elderly. • Mid-morning coffee break introduced to help prevent staff isolation and increase inclusivity.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to

the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.